DEPARTMENT OF HEALTH AND FAMILY SERVICES **STATE OF WISCONSIN**
Division of Health Care Financing
HCF 11179 (09/06)

WISCONSIN MEDICAID

PRIOR AUTHORIZATION / PREFERRED DRUG LIST (PA/PDL) FOR HYPOGLYCEMICS FOR ADJUNCT THERAPY

INSTRUCTIONS: Type or print clearly. Before completing this form, read the Prior Authorization/Preferred Drug List (PA/PDL) for Hypoglycemics for Adjunct Therapy Completion Instructions, HCF 11179A.

Pharmacy providers are required to have a completed PA/PDL for Hypoglycemics for Adjunct Therapy signed by the prescriber before calling Specialized Transmission Approval Technology-Prior Authorization (STAT-PA) or submitting a paper PA request. Providers may call Provider Services at (800) 947-9627 or (608) 221-9883 with questions.

SECTION I — RECIPIENT INFORMATION

1. Name — Recipient (Last, First, Middle Initial)
2. Date of Birth — Recipient
3. Recipient Medicaid Identification Number

SECTION II — PRESCRIPTION INFORMATION

4. Drug Name and Strength
5. Date Prescription Written
6. Directions for Use
7. Name — Prescriber
8. Drug Enforcement Agency Number
9. Address and Telephone Number — Prescriber (Street, City, State, Zip Code, and Telephone Number)

SECTION IIIA — CLINICAL INFORMATION FOR BYETTA

10. Diagnosis — Primary Code and / or Description
11. Does the recipient have a diagnosis of Type II diabetes? ❑ Yes ❑ No
12. Has the recipient failed to achieve adequate glycemic control despite individualized diabetic medication management, such as a sulfonyurea, metformin? If yes, indicate the recipient's current medication therapy and most current HbA1c. ❑ Yes ❑ No
13. Is the recipient receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator? ❑ Yes ❑ No

SECTION IIIB — CLINICAL INFORMATION FOR SYMLIN

14. Does the recipient have a diagnosis of Type I or Type II diabetes? ❑ Yes ❑ No
15. Has the recipient failed to achieve adequate glycemic control despite optimal insulin management including the use of meal-time insulin? If yes, indicate the recipient's current medication therapy including insulin regimen. ❑ Yes ❑ No

Continued

SECTION IIIB — INFORMATION FOR SYMLIN (CONTINUED)

16. Does the recipient have any of the following: an HbA1c greater than 9 percent, recurrent severe hypoglycemia or hypoglycemic unawareness, or a diagnosis of gastroparesis? Indicate the most current HbA1c value. ❑ Yes ❑ No

17. Is the recipient receiving ongoing medical care from a health care professional trained in diabetes management, such as a certified diabetic educator? ❑ Yes ❑ No

18. **SIGNATURE** — Prescriber	19. Date Signed

SECTION IV — FOR PHARMACY PROVIDERS USING STAT-PA

20. National Drug Code (11 digits)	21. Days' Supply Requested (up to 365 days)

22. Wisconsin Medicaid Provider Number (Eight digits)

23. Date of Service (MM/DD/YYYY) (For STAT-PA requests, the date of service may be up to 31 days in the future and / or up to four days in the past.)

24. Place of Service (Patient Location) (Use patient location code "00" [Not Specified], "01" [Home], "04" [Long Term / Extended Care], "07" [Skilled Care Facility], or "10" [Outpatient].)

25. Assigned PA Number (Seven digits)

26. Grant Date	27. Expiration Date	28. Number of Days Approved

SECTION V — ADDITIONAL INFORMATION

29. Include any additional information in the space below. For example, providers may include that this PA request is being submitted for a recipient who was granted retroactive eligibility by Wisconsin Medicaid, BadgerCare, or SeniorCare.

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